MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12284

Reg. Dist. No. 24

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Crownsville P.O.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Waterbury
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME** Morgan H. Baldwin

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | married |

6.(b) Name of husband or wife: Olive Hill Baldwin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 18th 1872

8. AGE: Years 68 | Months 3 | Days | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Postmaster (Crownsville)

11. Industry or business:

FATHER
12. Name: Reginal W. Baldwin
13. Birthplace: Maryland

MOTHER
14. Maiden name: Rosa E. Hall
15. Birthplace: Maryland

16. Informant: Morgan H. Baldwin Jr.
Address: Waterbury a/a Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 18th 1940 (month). (day) (year)
Cemetery or crematory: Baldwin Memorial Church
Location: Waterbury a/a Co Md.

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. Dec 17th 1940 (Date rec'd by registrar) J.F.M. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16 1940, at 9.07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~[illegible]~~ to ~~[illegible]~~ 19..; that I last saw deceased alive on ~~[illegible]~~ 19..; that to the best of my knowledge and belief death was due to the cause(s) and in the manner stated below; and that I have viewed the body after death. Post mortem examination

| Immediate cause of death | DURATION |
|---|---|
| Coronary occlusion | Sudden |
| Due to: Arterio-sclerosis | 10 years |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffey Deputy coroner & examiner
M. D. or other
Address: Anne Arundel Date signed: 12/17/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JAN 2 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

12285

WITHIN CORPORATE LIMITS OF

# CERTIFICATE OF DEATH

Reg. Dist. No. 24

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? unknown

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 74 Cathedral st
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Thomas Baldwin

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Col. | married |

6.(b) Name of ~~husband or~~ wife: deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): unknown

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| About 70 | | | ..... hrs. ..... min. |

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknow

16. Informant: Elnor Worsly

Address: 74 Cathedral st.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 29, 1940 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: On Washington rd outside Annapolis

18. Funeral director: Chas H Alexander

Address: 49 & 45 North West

19. 12 27 1940 (Date rec'd by registrar) J. M. Murphy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25 1940, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 1940, to Dec 25 1940 and that I last saw him alive on Dec 23 1940

| Immediate cause of death | DURATION |
|---|---|
| Chr. Myocarditis | ? |
| Due to Chr. Nephritis | ? |
| Due to | |
| Other conditions: Similitry (Include pregnancy within 3 months of death) | |

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: M. F. Klawans, M.D. (M. D. or other)

Address: 31 Smith Gate Av Date signed: 12/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1941
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

12286

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? pronounced dead on arrival

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? pronounced dead on arrival

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington (If outside city or town limits, write RURAL and give nearest town)

Street No. 1223 Simms Pl. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3. (a) FULL NAME:** Frettie O. Barrett

**3. (b) Social Security Number:**

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Inez B. Barrett

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 31 – 1894

8. AGE: Years 46 | Months 10 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace: Lexington South Carolina (Town, county, and state)

10. Usual occupation: Fine Type Operator Govt

11. Industry or business: U.S. Govt.

FATHER
12. Name: unknown
13. Birthplace: S. C.

MOTHER
14. Maiden name: unknown
15. Birthplace: S. C.

16. Informant: Inez B. Barrett wife

Address: 1223 Simms St. N.E.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 23rd, 1940 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington, Virginia

16. Funeral director: The S.H. Hines Co

Address: 2901 – 14th St. N.W.

19. 12 22 1940 (Date rec'd by registrar) J. J. Murphy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 1940, at 1 10 A.M.

21. I CERTIFY that death occurred on the date above stated: ~~[illegible]~~ Post-mortem examination ~~[illegible]~~ Dec. 22 1940.

Immediate cause of death: Fracture of Skull (base) Fracture of neck

~~Due to~~ Hemorrhage

Due to: automobile which he was driving hit culvert

Other conditions: throwing him into ditch

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ..... Date of op.

Autopsy results: ..... / /

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of 12/21/40

Where did injury occur? Mayo (City or town) Anne Arundel (County) Md. (State)

Injured at home, farm, industry, public place (where?) Mayo Road.

Means of injury: automobile collision Injured at work? No

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis, Md. Date signed 12/22/40.

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JAN 2 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8

# CERTIFICATE OF DEATH

12287

Reg. Diat. No. 23

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 914 Francis St.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Hazel Dawn Elizabeth Bast

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct 24 - 1931

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 9 | | 24 | hrs. min. |

9. Birthplace: Eastport A.A.C. Md (Town, county, and state)

10. Usual occupation: School

11. Industry or business

FATHER — 12. Name: William Bast

13. Birthplace: Annapolis Md

MOTHER — 14. Maiden name: Christine Walker

15. Birthplace: Balto Md.

16. Informant: William Bast

Address: 914 Francis St. Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 21st 1940 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md

18. Funeral director: John M. Saylor

Address: Annapolis Md

19. Dec. 20th 1940 (Date rec'd by registrar) J. J. Munley Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19 1940, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 7 1940, to Dec 19 1940

and that I last saw h[illegible] alive on Dec 19 1940

| Immediate cause of death | DURATION |
|---|---|
| Acute Myocarditis | Dec. 19 |
| Acute Pneumonia | Dec. 15 |
| Due to Scarlet Fever | Dec 7 |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: George C Bond M. D. or other

Address: Annapolis Md Date signed 12-20-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

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JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (118)

# CERTIFICATE OF DEATH

12288

Reg. Dist. No. 22

**1. PLACE OF DEATH:**
County A. A.
City or town Annapolis Jct.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County A. A.
City or town Annapolis Jct. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Audrey Bright.

**3. (b) Social Security Number**

4. Sex F
5. Color or race W
6. (a) Single, married, widowed, or divorced Single
6 (b) Name of husband or wife —
6(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) Sept 24th 1940
8. AGE: Years 0 Months 2 Days 21 If less than one day hrs. min.
9. Birthplace Odenton Md (Town, county, and state)
10. Usual occupation
11. Industry or business
FATHER 12. Name James W. Bright Jr.
13. Birthplace N. Carolina
MOTHER 14. Maiden name Audrey Keen
15. Birthplace Md.
16. Informant James W. Bright Jr.
Address Annapolis Jct Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 15-40 (month) (day) (year)
Cemetery or crematory Ivy Hill
Location Laurel Md
18. Funeral director Lloyd Kaiser
Address Laurel Md.
19. Dec 15 1940 (Date rec'd by registrar) Clara M Hasbrup Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12 13 1940, at 1 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 13 40, to 12 13 1940, and that I last saw her alive on 12 13 1940.
Immediate cause of death Morosmus.
Baby was dead, when physician arrived.
Due to Persistent vomiting.
Due to Cannot state exact cause of death. No more obtainable. C.W.G.R.
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION
11-22 40

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. R. Warren M. D. or other
Address Laurel Md Date signed 12 15 40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JAN 9 1941
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-6)

12289

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: A. A.

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 14 Block st

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md County: A. A.

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Hattie Burleigh

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Fem | colored | single |

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 9 1914

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 26 | 7 | 10 | ... hrs. ... min. |

9. Birthplace: Annapolis (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER
12. Name: John Burleigh
13. Birthplace: md

MOTHER
14. Maiden name: Josephine Gembly
15. Birthplace: Annapolis

16. Informant: Josephine Burleigh
Address: 14 Block st

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 23 40 (month) (day) (year)

Cemetery or crematory: St Marys

Location: Annapolis

18. Funeral director: J. B. Johnson
Address: Annapolis

19. Dec 22nd 1940 (Date rec'd by registrar) J. J. Murphy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 19 1940, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1940, to Dec 19 1940 and that I last saw her alive on Dec 18 1940

Immediate cause of death: Pulmonary tuberculosis — DURATION: 1 yr +

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: M. F. Klawans Md M. D. or other

Address: 31 Smithfield Av Date signed: 12/22/40

Dr Klovana

RECEIVED
JAN 6 1941
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

12290

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Chesapeake Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** John Westley Burton

**3. (b) Social Security Number**

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widower

6.(b) Name of husband or wife: Mary Burton

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feby 2d 1853

**8. AGE:** Years: 87 Months: 10 Days: 26 If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Ships carpenter Ret.

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Grover Emrick

Address: Chesapeake Ave Eastport Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec 30th 1940 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. 12 30 1940 (Date rec'd by registrar) J. J. Murphy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 27 1940, at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 4 1940, to Dec 27 1940 and that I last saw h. 1 M alive on Dec 27 1940

Immediate cause of death: Myocardial failure

Due to: Arteriosclerotic C.V.R. disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E. Linfield Hill M. D. or other

Address: Eastport, Md Date signed 12-29-40

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JAN 6 1941
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (147-d)

12291

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Ann A —

City or town: Smithville Road.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred: Smithville Road

How long in hospital or institution? No

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Amerindal

City or town: Smithville Road
(If outside city or town limits, write RURAL and give nearest town)

Street No. — —
(If rural, give LOCATION)

2.(a) If veteran, name war — —

**3. (a) FULL NAME:** Marion - Butler.

**3. (b) Social Security Number**

4. Sex: Fem

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Wilson Butler
Annapolis Md.

6.(c) If alive, give age: 42. years

7. Birth date of deceased (mo., day, yr.): Jan - 28 1911

**8. AGE:** Years: 29. Months: 10 Days: 4 If less than one day: — hrs. — min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Domestic at Home.

FATHER
12. Name: Thomas Jones.
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Isebell Tyler
15. Birthplace: Annapolis Md.

18. Informant: Brewerhill Cemt.
Address: Annapolis Md.

17. Brewerhill (Burial, cremation, or removal, Which?) Date thereof: Dec - 5 1940 (month) (day) (year)

Cemetery or crematory: Brewerhill Cemt

Location: Annapolis Md

18. Funeral director: E. H. B. Parker
Address: 47 Washington St

19. Dec. 5th, 1940 (Date rec'd by registrar) J. J. Murphy Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Dec. 2 1940, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated: Post mortem examination
Dec. 2 1940

Immediate cause of death: Puerperal Sudden death

Due to: Acute Cardiac Collapse

Due to: (was in labor for 48 hours or more without very much progress)

Other conditions:
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffey Deputy medical examiner. M. D. or other

Address: Annapolis, Md. Date signed: 12/3/40

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JAN 6 1941
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-7)

12292

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 2 hours

Hospital, Institution or street address where death occurred: Emergency Hospital

How long in hospital or institution? about 2 hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: McKendree
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Lothian, P.O.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** McLane Butler

**3.(b) Social Security Number**

4. Sex: Male

5. Color or race: negro

6.(a) Single, married, widowed, or divorced: married

6.(b) Name ~~of husband or~~ wife: Iva Butler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): ✓ unk.

**8. AGE:** Years: 27 | Months: | Days: | If less than one day ..... hrs. ..... min.

9. Birthplace: McKendree Md
(Town, county, and state)

10. Usual occupation: farm labor

11. Industry or business

FATHER
12. Name: John M. Butler
13. Birthplace: A. A. Co.

MOTHER
14. Maiden name: Ella Stenson
15. Birthplace: Greenock

16. Informant: James Butler
Address: Fraceys Landing

17. Burial (Burial, ~~cremation, or removal. Which?~~) Date thereof: Dec. 3 1940 (month) (day) (year)

Cemetery or ~~crematory~~: Union Chapel Cem

Location: McKendree Md.

18. Funeral director: F. A. Stardisty & Son
Address: Galesville Md.

19. Dec 2 1940. (Date rec'd by registrar) J. J. Murphy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 1 1940, at 10 55 A.M.

21. I CERTIFY that death occurred on the date above stated; ~~[illegible]~~
Post-mortem examination
~~[illegible]~~ Dec. 1 1940

| Immediate cause of death | DURATION |
|---|---|
| Suicide | |
| Due to: by drinking carbolic acid | 8 to 9 hours |
| Due to: Alcoholism | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Suicide Date of: Dec 1, 1940

Where did injury occur? McKendree (City or town) A.A. (County) Md. (State)

Injured at home, farm, industry, public place (where?): at home

Means of injury: drank crude carbolic acid Injured at work? no

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis, Md. Date signed: 12/1/40

RECEIVED
JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12293

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 3 months, 14 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1008 N. Bond Street

(If rural, give LOCATION)

2.(a) If veteran, name war: --------

**3. (a) FULL NAME**

HENRY CHEEK

**3. (b) Social Security Number**

---------

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | black | widowed |

B.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1861

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 79 | Unknown | | .....hrs. .....min. |

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Junkman

11. Industry or business: -----

FATHER 12. Name: Jack Cheeck

FATHER 13. Birthplace: North Carolina

MOTHER 14. Maiden name: Emily

MOTHER 15. Birthplace: North Carolina

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-14-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt

Address

Dec 14 1940 (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 6th 1940 at 12:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 23rd 1940 to Dec. 6th 1940 and that I last saw him alive on Dec. 6th 1940

Immediate cause of death: Marked generalized arteriosclerosis — DURATION:

Due to: Cerebral edema with congestion and atrophy

Due to: Chronic pancarditis with aortic stenosis and moderate hypertrophy of the left heart

Other conditions: Chronic nephritis - small lipoma of the ant. surface of the left kidney

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry E. Lemmer M.D. John M. Claffy Deputy medical M/D. Examiner

Address: Annapolis Md Date signed: 12/9/40

RECEIVED
JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

# CERTIFICATE OF DEATH

12294

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A1b

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 15 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Cambridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 3 Dunn Lane

(If rural, give LOCATION)

2.(a) If veteran, name war: ------

**3.(a) FULL NAME:** CHARLES CHRISTIAN

**3.(b) Social Security Number:** ------

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Male | Married |

6.(b) Name of husband or wife: Sarah Lizzie Christian

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1880

| 8. AGE: | Years | Months | Days | If less than one day |
|---|---|---|---|---|
| | 60 | Unknown | | ...hrs. ...min. |

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ------

FATHER 12. Name: John H. Christian

13. Birthplace: Maryland

MOTHER 14. Maiden name: Mary (Unknown)

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Dec. 16/1940 (month) (day) (year)

Cemetery or crematory: Federal Beach

Location:

18. Funeral director: Lewis H. Bargamin

Address: Cambridge Md

19. 12/14 1940 J. J. Murphy (Date rec'd by registrar) (Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12th 1940 at 12:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov. 28th 1940, to Dec. 12th 1940

and that I last saw h... alive on Dec. 12th 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebralhemorrhage no paralysis | |
| Due to | |
| Due to | |
| Other conditions: Generalized arteriosclerosis | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.: ------

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: Injured at work?

23. SIGNATURE: Clerk V. Mr. Brady M. D. or Other

Address: Crownsville, Md. Date signed: 12/12/40

#7037

Charles A. Christian
Dorchester County
Admitted Nov. 28th, 1940
Died Dec. 12th, 1940

RECEIVED
JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (97)

# CERTIFICATE OF DEATH

12295

Reg. Dist. No. 23

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Glen Burnie
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Light Street Road.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 50 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: A.A.
City or town: Glen Burnie Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Light St. Rd near 6th Ave N.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Clara Barbara Clauss

**3. (b) Social Security Number:** None

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Wm. H. S. Clauss
6(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): July 21, 1873

**8. AGE:** Years: 67 Months: 4 Days: 21 If less than one day: hrs. min.

9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own home

FATHER
12. Name: Bliesteiner
13. Birthplace: Germany.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mr. Wm. H. Clauss Sr.
Address: Glen Burnie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/14/15 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Anne Arundel Co.

18. Funeral director: Thomas W. Dingleton
Address: Glen Burnie, Md.

19. Dec. 13 1940 (Date rec'd by registrar) Mr. DeAlba Dep. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12, 1940, at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1935, to Dec. 12, 1940, and that I last saw her alive on December 11, 1940.

Immediate cause of death: Heart failure (partial block) — DURATION: 1 week
Due to: Arteriosclerosis — 3 years
Due to:
Other conditions:
(Include pregnancy within 8 months of death)
Major findings:
Of operations:
Of autopsy: None.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: None Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry M. Moore M.D. M. D. or other
Address: Glen Burnie, Md. Date signed: 12-12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1941
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12296

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 8 yrs. 9 mos. 25 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 857 West Fairmont Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

**3.(a) FULL NAME:** LILLY CLEA

**3.(b) Social Security Number:** -----

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | black | married |

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1902

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 38 | Unknown | | ..... hrs. ..... min. |

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unknown

FATHER
12. Name: Frank McDonald
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Smith
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: 12/12-40 (month) (day) (year)

Cemetery ~~or crematory~~: Hospital

Location: Crownsville Md.

18. Funeral director: Supt.

Address

19. 12/12/1940
(Date rec'd by registrar)

E. A. Joyce
Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 8th 1940 at 9:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 13th 1931 to Dec. 8th 1940 and that I last saw her alive on Dec. 8th 1940

Immediate cause of death: Pulmonary tuberculosis

Due to:

Due to:

Other conditions: ------

(Include pregnancy within 3 months of death)

Major findings of operations: -----

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury: Injured at work? ----

23. SIGNATURE: Robert S. Mills Eng. M. D. or other

Address: Crownsville, Maryland Date signed: 12/8/40

RECEIVED
JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

(93-d)

12297

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County A.A.

City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 Day's

Stay in this community (yrs., or mos., or days) 4 Months

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 101 Archwood Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Anna E. Croft

**3. (b) Social Security Number** None

4. Sex F

5. Color or race W

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife John A. Croft

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 3 1868

**8. AGE:** Years 72 Months 9 Days 10 If less than one day hrs. min.

9. Birthplace England
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name James D. Little
13. Birthplace England

MOTHER
14. Maiden name Elizabeth Turner
15. Birthplace England

16. Informant John D. Hudgins
Address 101 Archwood Ave. Annapolis.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 16 1940 (month) (day) (year)
Cemetery or crematory Sunset. Memorial
Location Minneapolis, Minn.

18. Funeral director B.L.Hopping
Address Annapolis, Md.

19. 12-14 1940 (Date rec'd by registrar) J.J.Messfeld Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 13 1940, at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 1940, to Dec. 13 1940, and that I last saw her alive on Dec. 13 1940.

Immediate cause of death: 1) Acute Dilatation of the Heart — DURATION: Immediate

Due to 2) Myocarditis (Chronic) — 1 yr.

Due to 3) Hypertension — 1 yr.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson M. D. or other
Address Annapolis, Md Date signed 12/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12298

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 6 months, 23 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME**

CHARLES HENRY DIGGS

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Negro | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | Unknown | | ..... hrs. ..... min. |

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Cook

11. Industry or business

FATHER

12. Name: Jacob Diggs

13. Birthplace: Maryland

MOTHER

14. Maiden name: Marie Boyd

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 1/3/41 (month) (day) (year)

Cemetery or crematory: Hospital Cem.

Location: Crownsville

18. Funeral director: Supt

Address

19. Jan 3 1941 (Date rec'd by registrar) E. J. Joyce Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 24, 1940, at 6.16 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 31, 1940, to December 24, 1940 and that I last saw him alive on December 24, 1940

| Immediate cause of death | DURATION |
|---|---|
| General Paralysis of the Insane | Unknown |
| Due to: | |
| Due to: | |
| Other conditions: Generalized Arteriosclerosis | Unknown |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fred E. Ambrose M. D. or other

Address: Crownsville, Maryland Date signed: 12/24/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
FEB 3 1941
BUREAU V.S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

12299

46-R

**1. PLACE OF DEATH**

County A. A. Registration Dist. No. 25

Village or City Margate No. 1 Margate Drive St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town where death occurrad ... yrs. ... mos. ... ds. How long in U. S. If of foreign birth? ... yrs. ... mos. ... ds.

**2. FULL NAME** Mary F. Hilpon If U. S. Veteran, specify WAR ...

(a) Residence: No. Margate A.A.Co. Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| Female | White | Widow |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Robert E. L. Hilpon

6. DATE OF BIRTH (month, day, and year) Oct. 31. 1869

| 7. AGE Years | Months | Days | If LESS than 1 day, ... hrs. or ... min. |
|---|---|---|---|
| 71 | 1 | 29 | |

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. none

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. ...

10. Date deceased last worked at this occupation (month and year) ...

11. Total time (years) spent in this occupation ...

12. BIRTHPLACE (city or town) (State or country) Balto., Md

FATHER

13. NAME ~~Michael~~ Jas. McNamee

14. BIRTHPLACE (city or town) (State or country) Ireland

MOTHER

15. MAIDEN NAME ~~Mary~~ Anna Cummings

16. BIRTHPLACE (city or town) (State or country) Ireland

17. INFORMANT Robert Hilpon

(Address) 3 E. Midland Road

18. BURIAL, CREMATION, OR REMOVAL Place Cathedral Cem. Date Jan. 2., 19 41

19. UNDERTAKER Margaret J. Flynn

(Address) 142 S. Light

20. FILED Dec 30, 1940 John M. Whitson Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** December 29, (Month) (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from September, 1940, to Dec 29, 1940

I last saw h-er alive on Dec 28, 1940; deeth is seld to have occurred on the date stated above, at 4 00 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance ware as follows:

| | Date of onset |
|---|---|
| Carcinoma of Rectum | unknown |

Other Contributory Causes of Importance:

| | |
|---|---|
| Carcinomatosis | — |

Name of operation Caecotomy Dete of Oct. 1940

What test confirmed diagnosis? Operation Was there an autopsy? no

23. If death wes due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ... Date of Injury ..., 19...

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of Injury ...

Nature of Injury ...

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify ...

(Signed) Lawrence McLean M. D.

(Address) 1029 Annapolis Blvd.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

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Example II

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12300

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 10 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown (If rural, give LOCATION)

2.(a) If veteran, name war: -------

**3. (a) FULL NAME:** CLARK DYSON

**3. (b) Social Security Number:** -------

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | black | unknown |

6.(b) Name of husband or wife: ------

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1865

**8. AGE:** Years: 75 Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: ------

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 11, 1940 (month) (day) (year)

Cemetery or crematory: St. Joseph's

Location: Morganza, Md

18. Funeral director: H. C. Mattingley Sons

Address: Leonardtown, Md.

19. 12/10 1940 (Date rec'd by registrar) E F Joyce Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 4th 1940 at 5:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 25th 1940 to Dec. 4th 1940 and that I last saw him alive on Dec. 4th 1940

Immediate cause of death: Chronic myocarditis

Due to:

Due to:

Other conditions: Senility

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: -----

Date of op.

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ----- Date of

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury: Injured at work? ------

23. SIGNATURE: Robert P. Minkrodt M. D. or other

Address: Crownsville, Md. Date signed: 12/4/40

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12301

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(94a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years

Hospital, institution, or street address where death occurred: —

How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 52 Cathedral St
(If rural, give LOCATION)

2.(a) If veteran, name war: World War, British Army

**3. (a) FULL NAME** Louis A. Ellison

**3. (b) Social Security Number**

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Ella Ellison

6.(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.): June 1, 1885

**8. AGE:** Years 55 | Months 6 | Days 17 | If less than one day ..... hrs. ..... min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: General merchandise

FATHER
12. Name: Joseph Ellison
13. Birthplace: Russia

MOTHER
14. Maiden name: Rose Nachman
15. Birthplace: Russia

16. Informant: Mrs. Ella Ellison

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 19 - 1940 (month) (day) (year)

Cemetery or crematory: Kneseth Israel

Location: Three mile oak

18. Funeral director: B. T. Hopping

Address: Annapolis, Md.

19. Dec 19 1940 (Date rec'd by registrar) J. J. Murphy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 18 1940 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem examination ~~and that I last saw him alive on~~ Dec 18 1940

Immediate cause of death: Coronary thrombosis — DURATION: sudden

Due to: Arteriosclerosis — unknown

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis, Md. Date signed: 12/18/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

12302

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

**1. PLACE OF DEATH:**

County A. A. Co.

City or town Rural Near Pindall Station
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Bristol P.O. Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Near Pindall Station
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Stillborn I (Ennis)

3. (b) Social Security Number

4. Sex Female

5. Color or race B

6. (a) Single, married, widowed, or divorced

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) December 10, 1940

8. AGE: Years Stillborn | Months | Days | If less than one day hrs. min.

9. Birthplace Bristol A. A. Co. Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Clarence Ennis
13. Birthplace Lothian A. A. Co. Md

MOTHER
14. Maiden name Mildred Wormley
15. Birthplace Washington D.C.

16. Informant Clarence Ennis
Address Bristol, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/10/40 (month) (day) (year)

Cemetery or crematory Courtney's Cemetery

Location Bristol Md

18. Funeral director Clarence Ennis
Address Bristol, Md

19. 12/10 1940 (Date rec'd by registrar) W. R. Clayton Dep Ltd Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Stillborn Dec. 10 1940, at 1230 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 ,
and that I last saw h alive on 19

Immediate cause of death Still born

Due to Lack of Prenatal Care

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. B. West M. D. or other
Address Lothian Date signed 12/10/40

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

## CERTIFICATE OF DEATH

12303

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County A. A. Co.

City or town Rural near Pindell Station
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County A. A. Co.

City or town Rural near Pindell Station
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Near Pindell Station
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Still born H. Ennis

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | B. | Single |

B (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) December 10, 1940

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| Still born | | | ____ hrs. ____ min. |

9. Birthplace Bristol P.O. A.A. Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Clarence Ennis
13. Birthplace Lothian A.A. Co. Md.

MOTHER
14. Maiden name Mildred Hasmley
15. Birthplace Washington D.C.

16. Informant Clarence Ennis
Address Bristol Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/10/40 (month) (day) (year)

Cemetery or crematory Courtney's Cemetery

Location Bristol Md

16. Funeral director Clarence Ennis

Address Bristol Md

19. 12/10 19 40 W. R. Clayton
(Date rec'd by registrar) Deputy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Still born Dec. 10 1940, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h____ alive on ____ 19____.

| Immediate cause of death | DURATION |
|---|---|
| Still born | |
| Due to Lack of Prenatal Care | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE T. B. West M. D. or other

Address Lothian Md Date signed 12/10/40

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

## CERTIFICATE OF DEATH

12304

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25yr. 2mo. 2days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 25yr. 2mo. 2days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ---------

**3.(a) FULL NAME:** Vivian Fisher

**3.(b) Social Security Number:** --------

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Black | Single |

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1889

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 51 | Unknown | | -- hrs. -- min. |

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -------

FATHER
12. Name: William H. Fisher
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville State Hospital

17. burial (Burial, cremation, or removal. Which?) Date thereof: 1/3/1 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: [illegible]

Address

19. Jan 3 1941 (Date rec'd by registrar) [illegible] Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1940 at 4:55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 28 1915, to December 30 1940 and that I last saw her alive on December 30 1940

| Immediate cause of death | DURATION |
|---|---|
| Carcanomatous Metastasis in Pericardium, Spleen and xxx Supravenal Gland | 2 years ago |
| Due to: Breast Carcanoma | |
| Other conditions: ------ | |

(Include pregnancy within 3 months of death)

Major findings of operations: --------

Date of op.: -----

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: -- Date of: --

Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: ------ Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Crownsville, Md. Date signed: 12/30/40

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93rd)

12305

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10yr.6mo.25days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 10yr.6mo.25days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Talbot

City or town: Unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ---------

**3. (a) FULL NAME**

CHARLES GIBSON #1

**3. (b) Social Security Number**

---

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | black | single |

6.(b) Name of husband or wife: Unknown

-------- 6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1860

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 80 | Unknown | | ___ hrs. ___ min. |

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 12/17-40 (month) (day) (year)

Cemetery ~~or crematory~~: Hospital

Location: Crownsville

18. Funeral director: Supt

Address: D

19. Dec 17 1940 (Date rec'd by registrar) E. F. Joyce Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Dec. 13, 1940, 6:30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18th 1930, to Dec. 13 1940 and that I last saw him alive on Decmeber 13 1940

Immediate cause of death: Chronic Myocarditis with Arteriosclerosis

Due to: Senility

Due to: ----------

Other conditions: ----------

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: --------

Date of op.

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of: ---

Where did injury occur? --------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: ----- Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 12/13/40

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-a)

# CERTIFICATE OF DEATH

12306

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County A.A.

City or town Camp Parole

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 21 Years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Camp Parole, Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Hattie Green

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | Col | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 23 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 28 | 2 | 13 | hrs. min. |

9. Birthplace Harwood, Md. (Town, county, and state)

10. Usual occupation House Work

11. Industry or business

FATHER 12. Name William H. Green

FATHER 13. Birthplace Maryland.

MOTHER 14. Maiden name Hattie Pindel

MOTHER 15. Birthplace Maryland

16. Informant William H.Green

Address Parole, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 9 1940 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis, Md.

18. Funeral director B.L.Hopping

Address Annapolis, Md.

19. Dec 9 1940 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6 1940, at 11:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 4 1940, to December 6 1940, and that I last saw h-- alive on December 6 1940.

| Immediate cause of death | DURATION |
|---|---|
| Pneumonia | 1 day |
| Due to | |
| Due to | |
| Other conditions Influenza (Include pregnancy within 3 months of death) | 3 days |

Major findings:

Of operations

Of autopsy

**PHYSICIAN** Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lawrence W. Green M. D. or other

Address Annapolis Date signed 12/8/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

12307

Reg. Dist. No. 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
County A. A.
City or town Drurie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Drurie
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** Mary Emily Griffin

**3. (b) Social Security Number**

4. Sex: Fem
5. Color or race: Color
6.(a) Single, married, widowed, or divorced: widow
8.(b) Name of husband or wife: Frank Griffin
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 10
8. AGE: Years: 64 Months: Days: If less than one day: hrs. min.
9. Birthplace: Calvert Co. (Town, county, and state)
10. Usual occupation: House work
11. Industry or business:
FATHER 12. Name: Thomas Blake
13. Birthplace: Calvert Co.
MOTHER 14. Maiden name: Lena Turner
15. Birthplace: Calvert Co.
16. Informant: Rosetta Johnson
Address: Ringgold's P.O. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 22 40 (month) (day) (year)
Cemetery or crematory: Moses
Location: Drurie
18. Funeral director: J. B. Johnson
Address: Annapolis
19. 12-22 1940 (Date rec'd by registrar) J. H. Murphy Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 18 1940 at 7:50 P.M.
21. I CERTIFY that death occurred on the date above stated: the ~~deceased from~~ I last attended deceased from ~~to~~ I last saw deceased alive on Dec. 18. 1940
I viewed the remains on ~~and last saw deceased alive on~~ Dec. 18. 1940
I performed autopsy on ~~and viewed the remains on~~ Dec. 18. 1940

| | DURATION |
|---|---|
| Immediate cause of death: Coronary Thrombosis | sudden |
| Due to: Arterio-Sclerosis | unknown |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations / Date of op. /
Autopsy results /
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide / Date of /
Where did injury occur? (City or town) / (County) / (State)
Injured at home, farm, industry, public place (where?)
Means of injury / Injured at work?

23. SIGNATURE John M. Lafty Deputy medical Examiner M. D. or other
Address Annapolis, Md. Date signed 12/20/40

JAN 6 1941
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12308

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2yr. 9mo. 3days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 2yr. 9mo. 3days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 238 S. Bethel Street
(If rural, give LOCATION)

2.(a) If veteran, name war: -------

**3.(a) FULL NAME**

James Hall

**3.(b) Social Security Number**

-----

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | black | widower |

6.(b) Name of husband or wife: Unknown

----- 6.(c) If alive, give age -- years

7. Birth date of deceased (mo., day, yr.): 1866

**8. AGE:** Years: 74 (?) Months: Unknown Days: If less than one day -- hrs. -- min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville State Hospital

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 18-1940 (month) (day) (year)

Cemetery or crematory: Mt. Calvary Cemetery

Location: Brooklyn, Maryland

18. Funeral director: Elroy Wilson

Address: 1000 Brantley Ave. Baltimore

19. Dec 15 1940 (Date rec'd by registrar) E F Joyce Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1940, at 8:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1938, to Dec. 15 1940 and that I last saw him alive on December 15 1940

| Immediate cause of death | DURATION |
|---|---|
| Arterioscleratic Heart Disease | |
| Due to: Generalized Arteriosclerosis | |
| Due to: ----- | |
| Other conditions: Senility | |
| Chronic Osteomyelitis of the right femur | |

(Include pregnancy within 3 months of death)

Major findings of operations: ------- Date of op. ---

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? -------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -------

Means of injury: --- Injured at work? ---

23. SIGNATURE: Joseph V. Kirkwood M. D. or other

Address: Crownsville, Md. Date signed: 12/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
DEC 21 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12309

## CERTIFICATE OF DEATH

Reg. Diat. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Greenock
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 39 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Greenock
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Route # 4
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME** Marjory Jane Hall

**3.(b) Social Security Number**

4. Sex: female
5. Color or race: Negro
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Chas. Hall
6.(c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr.): Sept. 29, 1874
8. AGE: Years: 66 Months: 2 Days: 16 If less than one day: hrs. min.
8. Birthplace: Anne Arundel Co. Maryland (Town, county, and state)
10. Usual occupation: —
11. Industry or business: — home
FATHER 12. Name: Bill Evans
13. Birthplace: Maryland
MOTHER 14. Maiden name: Dua Turner
15. Birthplace: Maryland.
18. Informant: Marjory Dellman
Address: Greenock. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 18/40 (month) (day) (year)
Cemetery or crematory: Moore's
Location: Drury Md
18. Funeral director: J. B. Thomas
Address: Annapolis
19. Dec 18 1940 (Date rec'd by registrar) J. H. Murphy Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Dec. 15 1940, at 3.45 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1. Last saw deceased alive on Dec. 15 1940
and that to the best of my knowledge death occurred at 3.45 A. M. on the date above stated.

| | DURATION |
|---|---|
| Immediate cause of death: Cerebral Hemorrhage | Sudden |
| Due to: Arterio-sclerosis | not known |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 12/15/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12310

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 1 year. 9 months, 28 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3129 Leads Street
(If rural, give LOCATION)
2.(a) If veteran, name war: -------

**3.(a) FULL NAME:** JOHN A. HAMILTON

**3.(b) Social Security Number:** ----

4. Sex: male
5. Color or race: black
6.(a) Single, married, widowed, or divorced: married
6.(b) Name of husband or wife: Frances Hamilton
6.(c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): 1869 ?

**8. AGE:** Years: 71 ? Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: West Virginia (Town, county, and state)
10. Usual occupation: Unknown
11. Industry or business: ----

FATHER
12. Name: Jesse Hamilton
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 11. 1940 (month) (day) (year)
Cemetery or crematory: Western Star Cemetery
Location: Baltimore, Md

18. Funeral director: Katie R Williams
Address: 322 N. Schroeder St. Baltimore

19. Dec 8 1940 (Date rec'd by registrar) E. F. Joyce Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7th 1940, at 11:35A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10th, 1939, to Dec. 7th 1940 and that I last saw him alive on Dec. 7th 1940

Immediate cause of death: General arteriosclerosis — DURATION:
Due to:
Due to:
Other conditions: Senility
(Include pregnancy within 3 months of death)
Major findings of operations: ----
Date of op.:
Autopsy results: -----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ----- Date of:
Where did injury occur? ----- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----
Means of injury: Injured at work? ----

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed: 12/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

12311

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 months, 19 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:** 1
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Lisbon
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** LIZZIE HAMMOND

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Negro | Widowed |

6.(b) Name of husband or wife: Unknown
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Unknown

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 ? | Unknown | | ..... hrs. ..... min. |

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business

FATHER
12. Name: Josh Sanders
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Eliza Gaither
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 31 1940 (month) (day) (year)
Cemetery or crematory: Bush Park
Location: near Cooksville Howard Co
18. Funeral director: H. M. Snyder
Address: Mt. Airy Md.
19. 12/29 1940 (Date rec'd by registrar) E. J. Joyce Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25, 1940, at 4.03 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 6, 1940, to December 25, 1940 and that I last saw her alive on December 25, 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | Unknown |
| Due to | |
| Due to | |
| Other conditions: Generalized Arteriosclerosis | Unknown |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clark T. Smith M. D. or other
Address: Crownsville, Maryland Date signed: 12/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 (1)

RECEIVED
JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

WITHIN CORPORATE LIMITS OF

## CERTIFICATE OF DEATH

12312

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH**
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 11 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County A A
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 175 Chestnut St
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Minnie Violet Henson

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | |

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 30 1940

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | 5 | 21 | hrs. min. |

9. Birthplace Annapolis (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Henson Henson
13. Birthplace Anne Arundel Co

MOTHER
14. Maiden name Gladys Jackson
15. Birthplace Anne Arundel Co

16. Informant Gladys Henson
Address 175 Chestnut St Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 24 1940 (month) (day) (year)
Cemetery or crematory Brewers Hill
Location On Washington Rd. outside Annapolis

18. Funeral director Chas N Alexander
Address 143 & 145 North West St

19. Dec 24 1940 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 21 1940, at 5:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1940, to Dec. 21 1940 and that I last saw her alive on Dec. 21 1940

| Immediate cause of death | DURATION |
|---|---|
| Bronchial Pneumonia | 1 week |
| Due to Influenza | |
| Due to | |
| Other conditions None | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson M. D. or other
Address Annapolis, Md Date signed 12/23/40

RECEIVED
JAN 6 1941
BUREAU V. S.

12313

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Odenton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Crisfield (If outside city or town limits, write RURAL and give nearest town)

Street No.: 236 N. Somerset Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME:** James Roger Hinman

**3. (b) Social Security Number:** 220-01-4051

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Lena May Hinman (LENA)

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Mar. 14, 1890

**8. AGE:** Years: 50 Months: 8 Days: 18 If less than one day: ..... hrs. ..... min.

9. Birthplace: Shelltown, Somerset Co. Md (Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business: general building

FATHER

12. Name: Chas. T. Hinman

13. Birthplace: Shelltown, Md

MOTHER

14. Maiden name: Mary W. Tibbitt

15. Birthplace: Delaware

16. Informant: Charles A. Hinman

Address: Crisfield, Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof: 12-4-40 (month) (day) (year)

Cemetery or crematory: Crisfield Cemetery

Location: Crisfield, Maryland

18. Funeral director: John A. Bradshaw

Address: Crisfield, Maryland

19. Dec 2 1940 (Date rec'd by registrar) W. L. Jones D.L. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 2 1940, at 2 45 M

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post mortem examination ~~and that I last saw him alive on~~ Dec. 2 1940

| Immediate cause of death | DURATION |
|---|---|
| Coronary occlusion | Sudden |
| Due to: | |
| Due to: Arterio-sclerosis | not known |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis, Md Date signed: 12/2/40.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 13 1940
BUREAU V. S.

12314

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County Anne Arundel

City or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Crownsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Henry M. B. Hopkins

**3. (b) Social Security Number**

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widower

6.(b) Name of husband or wife: Eleanor V. Hopkins

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 23rd 1861

**8. AGE:** Years 79 | Months 5 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Carpenter (ret)

11. Industry or business

FATHER
12. Name: Henry Hopkins
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs Roland Brady
Address: Crownsville A.A.Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 12th 1940 (month) (day) (year)

Cemetery or crematory: St Stephens

Location: Millersville A.A.Co Md

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. December 10th 1940 (Date rec'd by registrar) J. J. Murphy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 10 1940 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 9 1940 to Dec. 10 1940 and that I last saw him alive on Dec. 9, 1940 1940

| Immediate cause of death | DURATION |
|---|---|
| Coronary occlusion | 2-3 hrs. |
| Due to Generalized arteriosclerosis | ? |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE W. H. Fidler, M.D.
M. D. or other

Address 1318 West St., Annapolis Date signed 12-10-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1941
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

12315

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County A.A.

City or town Annapolis, (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 Day

Stay in this community (yrs., or mos., or days) 25 Years

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis, Md. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. West Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

**3. (a) FULL NAME** Joseph Hyatt

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1913

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 27 | 6 | 24 | hrs. min. |

9. Birthplace Salem North Carolina (Town, county, and state)

10. Usual occupation Clerk

11. Industry or business U. S. Goverment

FATHER 12. Name Smueal Hyatt

13. Birthplace Russia

MOTHER 14. Maiden name Yetta Sacks

15. Birthplace Russia

16. Informant Samual Hyatt

Address Annapolis, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 9 1940 (month) (day) (year)

Cemetery or crematory Keneseth Israel

Location Three Mile Oak

18. Funeral director B.L.Hopping

Address Annapolis, Md.

19. Dec 9 1940 (Date rec'd by registrar) J J Murphy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12 - 8 1940, at 8A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1940, to Dec 8 1940, and that I last saw him alive on Dec 8 1940.

Immediate cause of death Acute Myocarditis uremia

Due to Septicemia, Strepto coccus Verdicans

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: Dec 1st - Dec 3; 1 year

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C Basil M. D. or other

Address Annapolis Md Date signed 12-9-40

RECEIVED
JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1646)

## CERTIFICATE OF DEATH

12316

Reg. Dist. No. 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
County: Anne Arundel Co
City or town: East Port Md Spa Creek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Unknown
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: East Port
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 406 Chesapeake Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Agnes Adell Johnson

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Col. | Married |

6.(b) Name of husband: Theadora J Johnson
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 29, 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | 7 | 26 | hrs. min. |

9. Birthplace: Annapolis Md Anne Arundel Co
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Joseph Baden
13. Birthplace: Anne Arundel Co

MOTHER
14. Maiden name: Anna Duvall
15. Birthplace: Anne Arundel

16. Informant: Theadora J Johnson
Address: 406 Chesapeake Ave. East Port

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 25 1940 (month) (day) (year)
Cemetery or crematory: St. Mary's Cemetery
Location: on Washington Blvd outside Annapolis
19. Funeral director: Chas. A. Alexander
Address: 435 & 437 Forest Place

19. Dec. 27 1940 (Date rec'd by registrar) J. Harry Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Dec. 25 1940 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated: ~~Otherwise Examination~~ Post-mortem Examination
~~At the place where last seen alive~~ Dec. 25 1940

| Immediate cause of death | DURATION |
|---|---|
| Suicide by Drowning | |
| Due to: Ch. Alcoholism | Unknown |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: 12/25/40
Where did injury occur? near Annapolis Anne Arundel Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Spa Creek
Means of injury: drowning Injured at work? —

23. SIGNATURE: John M. Claffy Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 12/27/40

RECEIVED
JAN 6 1941
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

## CERTIFICATE OF DEATH

12317

Reg. Diat. No. 2-3

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**
County Anne Arundel
City or town Tolley
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or insl. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 18 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County A A Co
City or town Tolley Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Bertha L Johnson

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife Archibald
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 6 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | 4 | 20 | hrs. min. |

9. Birthplace Fayette Co Ill
(Town, county, and state)
10. Usual occupation Housework home
11. Industry or business
FATHER 12. Name Louis Meyers
13. Birthplace Ill
MOTHER 14. Maiden name E. Mary Hesemann
15. Birthplace Ill
16. Informant Mr Archibald Johnson
Address Tolley Md
17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec 27/40 (month) (day) (year)
Cemetery or crematory Tolley Home Cemetery
Location Tolley
18. Funeral director William M Marech
Address 715 Light St
19. Dec 26 1940 (Date rec'd by registrar) M Deale Dep Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 24 1940, at 3:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 26 1940 to Dec 24 1940, and that I last saw her alive on Dec 24 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral hemorrhage | 1 day |
| Due to Hypertension & Arteriosclerosis | 10 years |
| Due to Chronic Interstitial Nephritis | 10 years |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J Alexander M. D. or other
Address Glen Burnie Date signed 12/26/40

RECEIVED
JAN 6 1941
BUREAU V. S.

12318

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13 E)

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: H. A.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md County: H. A.

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 908 Central St. R.F.D.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1918.

**3. (a) FULL NAME** James Johnson

**3. (b) Social Security Number**

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Jeanne Johnson

6.(c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Jan. 7 1896

**8. AGE:** Years: 44 Months: 11 Days: 1 If less than one day: hrs. min.

9. Birthplace: Annapolis
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: James Johnson Sr.
13. Birthplace: H. A.

MOTHER
14. Maiden name: Mary Hall
15. Birthplace: H. A.

16. Informant: Mary Galloway
Address: Annapolis

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 10 1940
(month) (day) (year)

Cemetery or crematory: U.S. Nat.

Location: Annapolis

18. Funeral director: J. B. Johnson
Address: Annapolis

19. 12 10 1940
(Date rec'd by registrar)
J. J. Murphy
Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Dec. 8 1940, at 1:10 p.m.

21. I CERTIFY that death occurred on the date above stated; ~~[illegible]~~
Post-mortem examination 19
~~and that last [illegible]~~ Dec. 8. 1940

Immediate cause of death: Epileptiform seizure

Due to: Pulmonary Hemorrhages

Due to: Chronic Pulmonitis (gassed in France 1918. AEF.

Other conditions: Tuberculosis was the cause of this death. C.W.G.R.
(Include pregnancy within 3 months of death)

| DURATION |
|---|
| Sudden |
| 3 or 4 days |
| Since 1918 |

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy, Deputy Medical Examiner
M. D. or other

Address: Annapolis Md Date signed: 12/10/40

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
DEC 18 1940
BUREAU V

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

12319

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

**1. PLACE OF DEATH:**

County H. A.

City or town Lothian

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md. County H. A.

City or town Lothian

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Margrette Johnson

**3. (b) Social Security Number** None.

4. Sex: female

5. Color or race: negro

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife: John Johnson

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.)

**8. AGE:** Years 64 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Calvert (Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER 12. Name Louis West

13. Birthplace Calvert

MOTHER 14. Maiden name Rachiel Unknown

15. Birthplace Calvert

16. Informant Percy Johnson

Address Sudley P.O. A.A.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3, 1940 (month) (day) (year)

Cemetery or crematory Adams Chapel

Location Lothian, Md.

18. Funeral director J. B. Johnson

Address Annapolis

19. Dec 31 1940 (Date rec'd by registrar) W. R. Clayton Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Dec. 31 1940 at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 16 1940, to Dec 31 1940 and that I last saw h w alive on Nov. 16, 1940

Immediate cause of death Coronary thrombosis

Due to ?

Due to

Other conditions

(Include pregnancy within 3 months of death)

| DURATION |
|---|
| 1 min |

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emily H. Wilson, M. D. M. D. or other

Address Lothian, Md. Date signed 12/31/40

Authorization to add exp and color letter in permanent file under E. H. Wilson

5/3/41
M.G.

RECEIVED
JAN 6 1941
BUREAU V. S.

12320

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 23

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Tolley
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Marley Neck Rd

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 18 months

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md County: A A Co

City or town: Tolley Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Marley Neck Rd
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** James Jubb

**3. (b) Social Security Number:**

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Effie L

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan 31 1864

8. AGE: Years 76 | Months 10 | Days 6 | If less than one day ____ hrs. ____ min.

9. Birthplace: Lake Shore Md
(Town, county, and state)

10. Usual occupation: Store keeper

11. Industry or business:

FATHER
12. Name: George C Jubb
13. Birthplace: Md

MOTHER
14. Maiden name: Josephine Linstead
15. Birthplace: Md

16. Informant: Mr James Jubb
Address: Marley Rd

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 8 - 40 (month) (day) (year)

Cemetery or crematory: Magothy Church Cemetery

Location: Jacobsville A A Co

18. Funeral director: William M Mareck

Address: 715 Light St

19. Dec. 7 1940 (Date rec'd by registrar) M S DeAlba Dep. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 6 1940, at 8:55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/28/40 19__, to 12/6/40 19__, and that I last saw him alive on 12/5/40 19__.

Immediate cause of death: Hypostatic Pneumonia — DURATION: 2 days

Due to: Chronic Endocarditis

Due to: Chronic Nephritis

Arterio Sclerosis

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John J Alexander M. D. or other

Address: Glen Burnie Date signed: 12/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (1)

RECEIVED
JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

12321

# CERTIFICATE OF DEATH

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Anne Arundel

City or town Chalk Point near Churchton
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 60 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Chalk Point Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

**3. (a) FULL NAME** Elizabeth Walker Kirchner

**3. (b) Social Security Number** None

4. Sex: F.

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or ~~wife~~ William Kirchner

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 15 1865

8. AGE: Years 75 Months 7 Days 2 If less than one day hrs. min.

9. Birthplace Calvert Co. Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name George Walker

13. Birthplace Cal. Co.

MOTHER 14. Maiden name Sally Mayhew

15. Birthplace Cal. Co.

16. Informant Clarence Kirchner

Address Chalk Point A.A.Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 19 1940 (month) (day) (year)

Cemetery or crematory Quaker Cemetery

Location Galesville, Md.

18. Funeral director T. A. Hardesty & Son

Address Galesville Md.

19. Dec 17 1940 (Date rec'd by registrar) A. B. Dent Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1940, at 4 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 13th 1938, to Dec 17 1940, and that I last saw h[illegible] alive on December 14 1940.

Immediate cause of death Chronic Myocarditis — DURATION 5 Yrs.

Due to

Due to

Other conditions Chronic Cystitis — 6 Mo.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. B. West M. D. or other

Address Lothian Md. Date signed 12/17/40

JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12322

(97)

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 11 years, 11 months, 3 dy

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Snow Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**

ADDISON KERSEY

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Black | Married |

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown ?

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| ? 72 | unknown | | ..... hrs. ..... min. |

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3-1 (month) (day) (year)

Cemetery or crematory: Hospital Cemetery

Location: Crownsville Md

18. Funeral director: Supt.

Address

19. 1/3- 41 (Date rec'd by registrar) 19 ..... Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 25, 1940, at 8.25 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 22, 1929, to Dec. 25, 1940 and that I last saw him alive on December 25, 1940

| Immediate cause of death | DURATION |
|---|---|
| Generalized Arteriosclerosis | Unknown |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Chas. L. Winslow M. D. or other

Address: Crownsville, Maryland Date signed 12/25/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 3 1941
BUREAU V.S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

12323

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Annapolis Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: 123 King Geo St. (If outside city or town limits, write RURAL and give nearest town)

Street No.: Annapolis Md (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Samuel N. Kidwell

**3.(b) Social Security Number**

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Melvenue Kidwell

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 14th 1871

**8. AGE:** Years: 69 Months: 1 Days: 9 If less than one day ..... hrs. ..... min.

9. Birthplace: Fairfax Va (Town, county, and state)

10. Usual occupation: Fisherman (Self)

11. Industry or business

FATHER: 12. Name: Unknown

13. Birthplace: Unknown

MOTHER: 14. Maiden name: Levenia Wills

15. Birthplace: Va.

16. Informant: Melvenue Kidwell

Address: 123 King Geo St Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 24th 1940 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md

18. Funeral director: John M. Taylor

Address: Annapolis Md

19. Dec 24 1940 (Date rec'd by registrar) J J Murphy Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: 12 22 1940, at 11 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1940, to Dec 22 1940

and that I last saw h..... alive on ..... 19

Immediate cause of death: Cor myocarditis

Due to: Arteriosclerosis

Due to:

Other conditions: Cardiac insufficiency 1 hr

(Include pregnancy within 3 months of death)

DURATION: 2 / 2

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: J J Murphy M D (M. D. or other)

Address: Annapolis Date signed: 10 24 40

RECEIVED
JAN 6 1941
BUREAU V. S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

12324

46-B

**1. PLACE OF DEATH**

County Anne Arundel Registration Dist. No. 21

Village or City No. Box 140 Severn Md St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U.S. if of foreign birth? ___ yrs. ___ mos. ___ ds.

**2. FULL NAME** Edward S. Kruszewski

(a) Residence: No. Box 140 Severn Md St., Crain Highway Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word): Single

5a. If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: SOCIAL-SECURITY # 217-01-0920

6. DATE OF BIRTH (month, day, and year): Dec. 26 - 1912

7. AGE: Years 28 | Months — | Days 4 | If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BODKKEEPER, etc.: Boiler Maker Helper

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: Md. Drydock

10. Date deceased last worked at this occupation (month and year): June 1940

11. Total time (years) spent in this occupation: 3 yrs

12. BIRTHPLACE (city or town) (State or country): Balto.

FATHER

13. NAME: Bernard Kruszewski

14. BIRTHPLACE (city or town) (State or country): Germany

MOTHER

15. MAIDEN NAME: Michalina Wozniak

16. BIRTHPLACE (city or town) (State or country): Germany

17. INFORMANT: Bernard Kruszewski

(Address) Box 140 Crain Highway

18. BURIAL, CREMATION, OR REMOVAL

Place Sacred Heart of Mary Jan 2, 1941

19. UNDERTAKER: Wm. S. Fialkowski

(Address) 2007 Eastern Ave

20. FILED Dec 31, 1940 M. DeAlba Dep. Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** December (Month) 30 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from October 25, 1940, to December 25, 1940

I last saw him alive on December 25, 1940; death is said to have occurred on the date stated above, at 1 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Carcinoma of Stomach | June 1940 |

Other Contributory Causes of importance:

Name of operation ___ Date of ___

What test confirmed diagnosis? ___ Was there an autopsy? ___

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? ___ Date of Injury ___, 19___

Where did injury occur? ___ (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury ___

Nature of Injury ___

24. Was disease or injury in any way related to occupation of deceased? ___

If so, specify ___

(Signed) Joseph Swidler M. D.

(Address) 2348 Eutaw Place

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

| Example I | | Example II | |
|---|---|---|---|
| The principal cause of death and related causes of importance were as follows: | Date of onset | The principal cause of death and related causes of importance were as follows: | Date of onset |
| *Arteriosclerosis* | *1915* | *Attack of epilepsy* | *1 week ago* |
| *Chronic interstitial nephritis* | *1921* | *Run over by street car* | *1 week ago* |
| *Cerebral hemorrhage* | *July 5, 1927* | *Peritonitis* | *3 days ago* |
| | | | |
| | | | |
| Other contributory causes of importance: | | Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* | *Gastroenteritis* | *1 year* |
| | | | |
| | | | |

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## ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-Q)

12325

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County Anne Arundel
City or town Nr. Jones Sta.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town (Nr.) Jones Sta.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Dividing Creek Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(d) FULL NAME** Cecelia Langley (Nee Rinehardt.

**3.(b) Social Security Number** None -

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | white | Married. |

6.(b) Name of husband or wife Thomas H. Langley Sr. 6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) January 7, 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 11 | 18 | hrs. min. |

9. Birthplace Baltimore. (Town, county, and state)
10. Usual occupation Housewife.
11. Industry or business Own Home.

FATHER
12. Name Frank Rinehardt.
13. Birthplace Germany

MOTHER
14. Maiden name Margaret King.
15. Birthplace Germany

16. Informant Mrs Mary McGee
Address 5311 - Elsrode Ave. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 28, 1940 (month) (day) (year)
Cemetery or crematory Langleys Private Cemetery
Location Dividing Creek Road. A.A. Co.

18. Funeral director Thomas W. Singleton
Address Glen Burnie, Md.

19. Dec. 27 1940 (Date rec'd by registrar) W. R. DeAlba Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 25 1940, at 11 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11/9/40 19 to 12/25/40 19 and that I last saw h... alive on 12/25/40 19

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Edema | 2 days. |
| Hypostatic Pneumonia | |
| Due to Chronic Endocarditis | Unknown |
| Chronic Interstitial Nephritis | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J. Alexander M. D. or other
Address Glen Burnie Md. Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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12326

# STATE OF MARYLAND—CERTIFICATE OF DEATH

131-a

**1. PLACE OF DEATH**

County Anne Arundel Registration Dist. No.

Village or City Annapolis No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** Mrs. Louisa League If U. S. Veteran, specify WAR

(a) Residence: No. 11 Francis St. St., Ward.

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) |
|---|---|---|
| Female | White | Widowed |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Martin League

6. DATE OF BIRTH (month, day, and year) March 15, 1854

| 7. AGE Years | Months | Days | If LESS than 1 day, hrs. or min. |
|---|---|---|---|
| 86 | 9 | 15 | |

**OCCUPATION**

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Own Home

10. Date deceased last worked at this occupation (month and year) 12/21/40 11. Total time (years) spent in this occupation 50

12. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

**FATHER**

13. NAME Wells

14. BIRTHPLACE (city or town) (State or country) Baltimore, Md.

**MOTHER**

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) Unknown

17. INFORMANT (Address) Mrs. Louise Beckett 4102 Reisterstown Rd., Balto.

18. BURIAL, CREMATION, OR REMOVAL Place Western Cemetery Date Dec 26, 1940

19. UNDERTAKER (Address) Harry H. Witzke 4101 Edmondson, Baltimore, Md

20. FILED 12-24-, 1940 J. H. Murphy Jr. Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** December 24, 1940 (Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from Dec. 21, 1040, 19 to Dec. 24, 1940, 19

I last saw her alive on Dec. 24, 1940, 19; death is said to have occurred on the date stated above, at 9:30 A. M.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

| | Date of onset |
|---|---|
| Cerebral Hemorrhage | 12-21-40 |
| | |
| | |
| | |
| | |
| Other **Contributory Causes** of importance: Hypertensive CVR Disease | |
| | |
| | |
| | |

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way releled to occupetion of deceased? No

If so, specify

(Signed) E. G. Linhardt M.D. M. D.

(Address) 3 Chesapeake Ave., Eastport, Md.

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

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**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

12327

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County A.A
City or town Edgewater.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 80 *3-19

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County A.A.
City or town Edgewater, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Minnie.Lee

**3. (b) Social Security Number** None

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Widow

6 (b) Name of husband or wife Joseph A.Lee
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 14 1860

8. AGE: Years 80 Months 3 Days 19 If less than one day hrs. min.

9. Birthplace South River (Town, county, and state)
10. Usual occupation None
11. Industry or business

FATHER
12. Name Marine D. Chaney
13. Birthplace Maryland

MOTHER
14. Maiden name Emma M. Gardner
15. Birthplace Maryland

16. Informant C. Crroll Lee
Address Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 5 1940 (month) (day) (year)
Cemetery or crematory St Marys
Location Annapolis, Md.

18. Funeral director B.L.Hopping
Address Annapolis,Md.

19. 12 5 1940 (Date rec'd by registrar) J J Murphy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 3 1940, at 11 08 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1940, to Dec 3 1940, and that I last saw her alive on Dec 3 1940.

Immediate cause of death Coronary Thrombosis — DURATION Sudden
Due to Arterial Sclerosis
Due to Hypertension
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Oliver Purvis M. D. or other
Address Ann of Nishat Date signed Dec 4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

12328

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Annapolis, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days): 10 das.

Stay in this community (yrs., or mos., or days): 4 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Arnold Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Shore Acres, a. 9. Co.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Harry M. Lewis

**3. (b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Divorced |

6 (b) Name of husband or wife: unknown

6 (c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 31, 1885

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 11 | 3 | ____ hrs. ____ min. |

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Handyman

11. Industry or business: General Store

FATHER
12. Name:
13. Birthplace:

MOTHER
14. Maiden name:
15. Birthplace:

16. Informant: Mrs. Hettie Gayleard

Address: Shore Acres, Arnold, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1940 (month) (day) (year)

Cemetery or crematory: Glen Haven Mem'l

Location: Anne Arundel Co. Md.

18. Funeral director: A. Howard Evans

Address: 1400 S. Charles St. Baltimore Md.

19. Dec. 3rd 1940 (Date rec'd by registrar) J. H. Murphy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 3 1940, at 4.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 24 1940 to Dec. 3 1940, and that I last saw him alive on Dec 2, 1940.

| Immediate cause of death | DURATION |
|---|---|
| +/ Cerebral Hemorrhage | Since 11/24/40 |
| Due to | |
| Due to 2/ Chronic Interstitial Nephritis | Since 12.1.40 |
| Other conditions 3/ Hernia (Include pregnancy within 3 months of death) | Since 12/4/40 |

Major findings:

Df operations: Yes

Df autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ____ Injured at work?

23. SIGNATURE: Albert L. Anderson M. D. or other

Address: Annapolis, Md. Date signed 12/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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12329

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 75 West St.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Baby May

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 31st 1940

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | | 3 hrs. min. |

9. Birthplace: Annapolis Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: Clark May

13. Birthplace: Annapolis Md.

MOTHER

14. Maiden name: Helen Busher

15. Birthplace: Baltimore Md

16. Informant: Clark May

Address: 75 West St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jany 2d 1940 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M Taylor

Address: Annapolis Md.

19. Jan. 2nd 1941 (Date rec'd by registrar) J M Mills Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 31 1940, at 9:41 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 31 1940, to Dec 31 1940 and that I last saw him alive on Dec 31 1940

Immediate cause of death: Phthalus Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: E Hinkley M.D. M. D. or other

Address: Annapolis Md Date signed 1-1-41

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Authorization to change from stillbirth to D.O.I. letter in permanent file, also duplicate cert., under E. L. Linhardt

1/20/41
H. J.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12330

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME** Laura Ellen McGonnigill

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6.(b) Name of husband or wife: Charles Edward McGonnigill
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March - 31 - 1855

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 85 | 8 | 4 | hrs. min. |

9. Birthplace: Shenandoah Va
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Jacob Allen
13. Birthplace:
MOTHER 14. Maiden name: Rhoda Freeman
15. Birthplace:
16. Informant: Mrs India Young (daughter)
Address: Gambrills
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 7. 1940 (month) (day) (year)
Cemetery or crematory: Woodlawn.
Location: Baltimore Md
18. Funeral director: Wm Cooke
Address: St Paul + Preston St Balto
19. Dec 5. 1940 (Date rec'd by registrar) E. T. Joyce Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 5 1940, at 7.40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3rd 1940, to Dec 5 1940
and that I last saw h... alive on December 5 1940
Immediate cause of death: Pneumonia bronchial — DURATION: 4 days
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: O H McNemar M. D. or other
Address: Millersville Md Date signed: Dec 5 - 40

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MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (83-a)

Reg. Dist. No. 27

12331

## CERTIFICATE OF DEATH

**1. PLACE OF DEATH:**

(a) County Anne Arundel

(b) City or town No. Linthicum (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Nursery Road.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 4 1/2 yrs.

**2. HOME (USUAL RESIDENCE) OF DECEASED:**

(a) State Md. (b) County A. A.

(c) City or town No. Linthicum (Lansdowne P.O.) (If outside city or town limits, write RURAL and give town)

(d) Street No. Nursery Rd. (If rural give location)

(e) If foreign born, how long in U. S. A.? 26 years

3 (a) **FULL NAME** Marie Agnes Schneider Miller.

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: George Miller

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 4 - 1855

8. **AGE:** Years 85 Months 8 Days 8 If less than one day ____ hr. ____ min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER

12. Name Gottlieb Schneider

13. Birthplace Germany

MOTHER

14. Maiden Name Marie ? Bochfick

15. Birthplace Germany

16 (a) Informant Mrs. Elise Steffen

(b) Address Nursery Rd - Lansdowne, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Dec. 15 1940 (month) (day) (year)

(c) Cemetery or crematory Lutheran

Location Taneytown, Md

18 (a) Funeral director C. O. Fuss & Son

(b) Address Taneytown, Md.

19 (a) 14 Dec 1940 (Date rec'd by registrar) (b) Caldwell Woodruff Registrar

### MEDICAL CERTIFICATION

20. Date of death December 12 1940, at 9:55 P. M

21. I certify that death occurred on the date above stated; that I attended deceased from July 8 1940, to Dec. 12 1940, and that I last saw him alive on Dec. 12 1940.

Immediate cause of death: Intestinal Obstruction — Duration: 3 days.

Due to Cerebral Haemorrhage — 7 days.

The intestinal obstruction was due to partial paralysis of the bowel, following a slight cerebral hemorrhage. It was not due to cancer. cwgr.

Other conditions Arterio-sclerosis — 15 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations No operation

Of autopsy No autopsy

**PHYSICIAN**

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature Chas. L. Ball, Jr., M.D. (M. D. or other)

Address Linthicum, Md. Date signed Dec. 12 - '40

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12332

108

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? since May 3. 1934

Hospital, institution, or street address where death occurred:

How long in hospital or institution? May 3. 1934

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: ~~Ann Montgomery~~ P.G.

City or town: Hyattsville (If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown (If rural, give LOCATION)

2.(a) If veteran, name war: //////

**3. (a) FULL NAME** Emily J.C. Minor

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | negro | widow |

6.(b) Name of husband or wife: unknown

//// 6.(c) If alive, give age: //// years

7. Birth date of deceased (mo., day, yr.): unknown

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | ? | ? | ? hrs. min. |

9. Birthplace: unknown Maryland (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: unknown

FATHER
12. Name: "
13. Birthplace: "

MOTHER
14. Maiden name: "
15. Birthplace: "

16. Informant: Hospital Records

Address: Crownsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12 27 40 (month) (day) (year)

Cemetery or crematory: Farmers

Location: Blakensburg Md

18. Funeral director: W. Ernest Jarvis

Address: 1432 - Youth St NW.

19. 12 25 1940 (Date rec'd by registrar) J. J. Murphy Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: 12.25.40 19 at 11 10a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3. 1934 19 to 12.25.40 19 and that I last saw her alive on 12. 25. 40. 19

Immediate cause of death: Lobar Pneumonia, rt. base Chronic Myocarditis

Due to:

Due to:

Other conditions: senility Generalized Arteriosclerosis (Include pregnancy within 3 months of death)

DURATION

Major findings of operations: none Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: none Date of

Where did injury occur? ///// (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) /////

Means of injury: ///// Injured at work? ///

23. SIGNATURE: Alec K. P. Harrison M.D. M. D. or other

Address: Date signed:

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# STATE OF MARYLAND—CERTIFICATE OF DEATH

12333

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

**1. PLACE OF DEATH**

County Anne Arundel Registration Dist. No. 27

Village or City Fort George G. Meade, Md. No. Station Hospital St., - Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 3 ds. How long in U. S. If of foreign birth? yrs. mos. ds.

**2. FULL NAME** Barbara Elaine Misener If U. S. Veteran, specify WAR

(a) Residence: No. Fort George G Meade, Md. St., - Ward. -

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) |
|---|---|---|
| Female | White | Single |

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of - -

6. DATE OF BIRTH (month, dey, end yeer) September 17, 1939

| 7. AGE | Yeers | Months | Deys | If LESS then I dey, hrs. or min. |
|---|---|---|---|---|
| | 1 | 3 | 3 | |

OCCUPATION

8. Trede, profession, or particular kind of work done, es SPINNER, SAWYER, BOOKKEEPER, etc. - -

9. Industry or business in which work wes done, es SILK MILL, SAW MILL, BANK, etc. - -

10. Dete decaased lest worked et this occupetion (month and year) -

11. Total time (yaars) spent in this occupetion -

12. BIRTHPLACE (city or town) Fort George G Meade,

(State or country) Maryland

FATHER

13. NAME Morris M. Misener

14. BIRTHPLACE (city or town) Welland,

(Stete or country) Candda

MOTHER

15. MAIDEN NAME Wanda R. Rynazewski

16. BIRTHPLACE (city or town) Bay City,

(State or country) Michigan

17. INFORMANT Morris M. Misener (Father)

(Address) Fort George G Meade, Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Ft. Geo G. Meade, Md. Dete Dec 23, 1940

19. UNDERTAKER T. A. HARDESTY & SON

(Address) Galesville, Md.

20. FILED Dec 23, 1940 D. P. CARD, Col., M.C.

Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** December (Month) 20, (Dey) 1940 (Yeer)

22. I HEREBY CERTIFY, That I ettended deceased from , 19 , to , 19

I last saw her alive on Dec 20, 1940; deeth is seid to have occurred on the dete stated above, et 9:00P. m.

The PRINCIPAL CAUSE OF DEATH and raleted causes of importence ware as follows:

| | Date of onset |
|---|---|
| Pneumonia, broncho, all lobes, both lungs, type undetermined. | 3 Days |
| Other Contributory Causes of importance: Whooping Cough | 3 Weeks |

Nema of oparation Date of

Whet test confirmed diegnosis? Was there en autopsy?

23. If deeth wes due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicida? Dete of injury , 19

Whare did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Mannar of Injury

Nature of Injury

24. Wes disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) MILO M. KIRK, 1st Lt., M.C. M. D.

(Address) Fort George G Meade, Md.

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a **clerk.**

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

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**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| **Other contributory causes of importance:** | |
| *Gallstones* | *May 1, 1928* |
| | |
| | |

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| **Other contributory causes of importance:** | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

**ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN**

VS A15 (1) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

12334

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Winchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 30 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Winchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R7 W2 Winchester Md.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Mary Anne Morris

**3.(b) Social Security Number:** none

4. Sex: F
5. Color or race: C
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband ~~or wife~~: Joseph Morris
6.(c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): Sept. 18, 1890

**8. AGE:** Years: 50 Months: -3 Days: -12 If less than one day: hrs. min.

9. Birthplace: Anne Arundel Co. Md.
(Town, county, and state)
10. Usual occupation: House wife
11. Industry or business:
FATHER
12. Name: Henry Lindsay
13. Birthplace: Anne Arundel Co
MOTHER
14. Maiden name: Sarah Price
15. Birthplace: Anne Arundel Co Md.
16. Informant: Joseph Morris
Address: Winchester Md. R7 W2
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 2 1941 (month) (day) (year)
Cemetery or crematory: Broad Neck Cemetery
Location: On Severn Side
18. Funeral director: Chas H Alexander
Address: 43 & 45 North West St
19. 1 2 1941 (Date rec'd by registrar) J J Minnick Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1940, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 1939, to Dec 30 1940 and that I last saw her alive on Dec 29 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral hemorrhage | 2 months |
| Due to: Hypertension | about 3 " |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr Ambrose Garcia M. D. or other
Address: 35 Northwest St Date signed: 1. 1. 40

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(108)

# CERTIFICATE OF DEATH

Reg. Dist. No. 12335

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: U.S. Naval Hospital

Stay in hospital or inst. (yrs., or mos., or days): 4 days

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 324 Washington, St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War

**3. (a) FULL NAME:** Hans (none) Olavesen

**3. (b) Social Security Number:**

4. Sex: Male

5. Color or race: W-US

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of ~~husband or~~ wife: Nellie Olavesen

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 10-2-77

**8. AGE:** Years: 63 Months: 2 Days: 14 If less than one day ____ hrs. ____ min.

9. Birthplace: Norway, Sweden
(Town, county, and state)

10. Usual occupation: Chief Boatswains Mate, US Navy

11. Industry or business: US Navy, Retired

FATHER
12. Name: Olaf Olavesen
13. Birthplace: Larvik, Norway

MOTHER
14. Maiden name: Christian Olavesen
15. Birthplace: Larvik, Norway

16. Informant: Mrs Nellie Olavesen

Address: 324 Washington, St. Eastport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 19th 1940 (month) (day) (year)

Cemetery or crematory: Naval Cemetery

Location: Annapolis Md

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. Dec. 17th 1940 (Date rec'd by registrar) J. J. Murphy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 16 1940, at 12 30 0020 9 h

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-12 1940, to 12-16 1940, and that I last saw him alive on 12-16 1940.

Immediate cause of death: Pneumonia, Hypostatic — DURATION: 2 days

Due to: Congestive Heart Failure — 3 weeks

Due to: Myocarditis, Chronic — Indefinite

Other conditions: General arteriosclerosis — Indefinite

(Include pregnancy within 8 months of death)

Major findings:

Of operations:

Of autopsy: Red hepatization thru out left lung fields + right lung fields

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: B. W. Hogan Lieut C. (MC) USN
M. D. or other

Address: U. S. N. Hospital, Annapolis Md. Date signed: 12-16-40

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12336

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Pasadena
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F. D.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Albert Otterbine

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Feby 13th 1889

8. AGE: Years 51 | Months 10 | Days 4 | If less than one day ... hrs. ... min.

9. Birthplace: Robinson Station A.A. Co Md.
(Town, county, and state)

10. Usual occupation: Salesman at Gas Station

11. Industry or business

FATHER
12. Name: George Otterbine
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Laura Davis
15. Birthplace: A. A. Co Md

16. Informant: John Otterbine
Address: Pasadena A.A. Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 20th 1940 (month) (day) (year)

Cemetery or crematory: Glen Haven Memorial Park

Location: Glen Burnie, Md.

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. 12 20 1940 (Date rec'd by registrar) J. J. Murphy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17, 1940, at 5:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 16 1940, to Dec 17 1940 and that I last saw him alive on Dec 17, 1940

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Hemorrhage | 5 minutes |
| Due to Pulmonary Tuberculosis | 14 years |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.: —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: James S. Billingslee M.D.
M. D. or other

Address: Glen Burnie Md. Date signed: Dec 19, 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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12337

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-b)

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

**1. PLACE OF DEATH:**

County A. A.

City or town Fishers
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County A. A.

City or town Fisher's
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Charles H. Owens

**3. (b) Social Security Number** none

4. Sex: Male

5. Color or race: Colored

6.(a) Single, married, widowed, or divorced: married

8.(b) Name of husband or wife: Sarah Owens

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.): Sept. 20 1881

**8. AGE:** Years 59 | Months 2 | Days 26 | If less than one day ... hrs. ... min.

9. Birthplace: A. A. Co. Md
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: John Owens
13. Birthplace: A. A. Co.

MOTHER
14. Maiden name: Alice Harried
15. Birthplace: A. A.

16. Informant: Sarah Owens
Address: Fisher's P.O.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 19/40
(month) (day) (year)

Cemetery or crematory: Union Chapel

Location: Bristol

18. Funeral director: J. B. Johnson
Address: Annapolis

19. 12/19 1940 (Date rec'd by registrar) W. R. Clayton Dep. Eng. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 16 1940 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 10 1940, to Dec. 16 1940 and that I last saw him alive on Dec. 14 1940

Immediate cause of death: Uremia

DURATION

Due to 1. Nephritis; acute. Duration: Unknown.
2. Infected pockets
Due to 3. Spitting

Other conditions: Physician only saw the patient three days before he died.
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F. B. Hunt M. D. or other

Address: Lothian Md Date signed 12/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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12338

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

**1. PLACE OF DEATH:**

County: A. A. Co.

City or town: Rural Near Harwood
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: A. A. Co.

City or town: Harwood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Rural Near Harwood P.O.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Margaret Parker

**3. (b) Social Security Number**

4. Sex: F

5. Color or race: B.

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.)

**8. AGE:** Years: Stillborn | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace: Harwood A.A. Co. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Elliot Claggett
13. Birthplace: Sutherland Calvert Co. Md.

MOTHER
14. Maiden name: Margaret Parker
15. Birthplace: BALTIMORE ~~A.A. Co.~~ Md.

16. Informant: Elliot Claggett
Address: Harwood, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 16, 1940 (month) (day) (year)
Cemetery or crematory: Geo Shepherd's Farm
Location: Harwood, Md

18. Funeral director: Elliott Clagett
Address: Harwood, Md

19. 12/16 1940 (Date rec'd by registrar) W. R. Clayton Dep'ty Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Born dead Dec 16 1940, at 12 05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Still born at seven months

Due to: not determined

Due to

Other conditions: Prenatal care
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: F B West M. D. or other
Address: Lothian Date signed: 12/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

12339

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County A. A.

City or town Annapolis

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County A. A.

City or town Parole Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Ruth Va. Phillips

3. (b) Social Security Number

4. Sex Fem

5. Color or race Colored

6. (a) Single, married, widowed, or divorced single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov. 28 1940

8. AGE: Years | Months | Days 7 | If less than one day hrs. min.

9. Birthplace Parole (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Harrison Sprigga

13. Birthplace A. A. Co.

MOTHER 14. Maiden name Ethel Phillips

15. Birthplace A. A. Co.

16. Informant Richard Phillips Jr.

Address Parole

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6 1940 (month) (day) (year)

Cemetery or crematory Churchton Cem.

Location Churchton

18. Funeral director J. B. Johnson

Address Annapolis

19. December 6th 19 (Date rec'd by registrar) J. J. Murphy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 4 1940, at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 28 1940, to Dec 4 1940, and that I last saw her alive on Dec 3 1940.

Immediate cause of death Hemorrhagic Purpura — DURATION 24 hrs.

Due to

Due to

Other conditions Premature infant (6 mo)

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy none.

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. F. Klewans, Md M. D. or other

Address 31 Southgate av Date signed 12/6/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (93-d)

12340

# CERTIFICATE OF DEATH

Reg. Dist. No. 26

**1. PLACE OF DEATH:**
County A. A. Co.
City or town Churchton Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Churchton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR None

**3. (a) FULL NAME** Andrew Jackson Phipps

**3. (b) Social Security Number** None

4. Sex M
5. Color or race W
6. (a) Single, married, widowed, or divorced Widower
6 (b) Name of husband or wife Mary Evans Phipps
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) June 19 1851
8. AGE: Years 89 Months 6 Days 3 If less than one day hrs. min.
9. Birthplace Churchton (Town, county, and state)
10. Usual occupation Plasterer
11. Industry or business
FATHER 12. Name John J. Phipps
13. Birthplace Churchton
MOTHER 14. Maiden name Rachael Randall
15. Birthplace Churchton, Md.
16. Informant Lena Phipps
Address Churchton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12 (month) (day) 40 (year)
Cemetery or crematory Quaker Cemetery
Location Galesville Md.
16. Funeral director T. A. Hardesty & Son
Address Galesville, Md
19. Dec. 24 1940 (Date rec'd by registrar) John Belle Dent Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12/22 1940, at 10 30 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1938, to December 21 1940, and that I last saw h im alive on December 21 1940.

Immediate cause of death
Arteriosclerosis — DURATION 20 years
Chronic Myocarditis — 5 years
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel M. Reichel M.D. M. D. or other
Address 1 Monroe Ct., Annapolis, Md. Date signed 12/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JAN 6 1941
BUREAU V. S.

12341

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 25

**1. PLACE OF DEATH:**

County Anna Arundel

City or town Mt Pleasant Beach
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 10 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County A A Co

City or town Mt Pleasant Beach Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Beach Drive
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Annie E Priddy

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widow

6 (b) Name of husband or wife William O

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 15 1862

**8. AGE:** Years 78 | Months 6 | Days 12 | If less than one day ____ hrs. ____ min.

9. Birthplace Obyon Co Tenn
(Town, county, and state)

10. Usual occupation Housework at home

11. Industry or business

FATHER
12. Name Jesse S. Lennox
13. Birthplace Tenn

MOTHER
14. Maiden name Annie E M Wilkens
15. Birthplace Tenn

16. Informant Mr Jesse R Lennox

Address Mt Pleasant Beach

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 30/40 (month) (day) (year)

Cemetery or crematory Loudon Park

Location Frederick Ave

16. Funeral director William M Mareck

Address 715 Light St

19. Dec 29 1940 (Date rec'd by registrar) Ida M. Whiteman Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 27 1940, at 12 30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19/40 19 , to Dec 27 1940, and that I last saw her alive on Dec 26th 1940

Immediate cause of death

Due to Angina Pectoris.

Due to Coronary Heart Disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

[illegible]

[illegible]

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John [illegible] M. D. or other

Address [illegible] Date signed 12/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

12342

(94a)

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: a-a-.

City or town: Annapolis Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years.

Hospital, institution, or street address where death occurred: No 14 Monument St Annapolis Md

How long in hospital or institution? — No

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: a-a-

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Monument St
(If rural, give LOCATION)

2.(a) If veteran, name war: — —

**3. (a) FULL NAME**: Mary Gray Ineen

**3. (b) Social Security Number**:

4. Sex: Fem-

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Maryland Ineen

6.(c) If alive, give age: about 60 years

7. Birth date of deceased (mo., day, yr.): May 22. 1882

**8. AGE:** Years: 58. Months: 6 Days: 25 If less than one day: — hrs. — min.

9. Birthplace: Waterbury a-a- Maryland.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: at Home.

FATHER
12. Name: Joseph Gray
13. Birthplace: Waterbury a-a- Md.

MOTHER
14. Maiden name: unknown.
15. Birthplace: — —

16. Informant: Ada Dorsey, The G- Child of

Address: 14 Monument Street

17. Brewerhill (Burial) Date thereof 12. 19. 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Brewerhill Cemt-.

Location: Annapolis Md.

18. Funeral director: E. H. B. Parker

Address: 47 Washington St

19. Dec 18th 1940 J. Murphy Registrar
(Date rec'd by registrar)

Dr Claffey

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Dec. 17 1940, at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; ~~[illegible]~~ Post-mortem examination ~~[illegible]~~ Dec. 17 1940

Immediate cause of death: Coronary Thrombosis — DURATION: sudden

Due to: Artero-sclerosis — 8 years

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John M. Claffey Deputy medical examiner M. D. or other

Address: Annapolis Md Date signed 12/18/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JAN 6 1941
BUREAU V. S.

12343

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: Pleasant Court (If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME:** Lorenza Richardson

**3.(b) Social Security Number:** none

4. Sex: Male

5. Color or race: Col.

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): August 2, 1898

8. AGE: Years 42 Months 4 Days 12 If less than one day ... hrs. ... min.

9. Birthplace: Anne Arundel Co. (Town, county, and state)

10. Usual occupation: Utility man in

11. Industry or business: Navy Academy

FATHER

12. Name: George Richardson

13. Birthplace: Anne Arundel Co.

MOTHER

14. Maiden name: Luvina Gross

15. Birthplace: Anne Arundel Co.

16. Informant: William Gross

Address: 119 Clay st. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 18 1940 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: On Washington rd. out side Annapolis Md.

18. Funeral director: Chas H. Alexander

Address: 43 & 45 North West Angelis

19. 12-17 1940 (Date rec'd by registrar) J. J. Murphy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 15 1940, at 8:45 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1940 to Dec. 15 1940 and that I last saw him alive on Dec. 15 1940

Immediate cause of death: Cerebral Hemorrhage — DURATION: Immediate

Due to:

Due to: Epilepsy (Jacksonian) — Unknown

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson Mrs. M. D. or other

Address: Annapolis, Md. Date signed: 12/15/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (131-a) Reg. Dist. No. 21 12344

# CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Rock Creek (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 8 months

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County A. A.
(c) City or town Rock Creek (If outside city or town limits, write RURAL and give town)
(d) Street No. P. O. Pasadena (If rural give location)
(e) If foreign born, how long in U. S. A.? 32 yrs. years

3 (a) FULL NAME Herman Roehnert

3 (b) If veteran, name war

3 (c) Social Security No. 215 - 01 - 5229

4. Sex: male

5. Color or race: white

6 (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 58 | Months | Days | If less than one day ____hr. ____min.

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Chef

11. Industry or business

FATHER
12. Name
13. Birthplace Germany

MOTHER
14. Maiden Name
15. Birthplace Germany

16 (a) Informant Charles Heintzmann
(b) Address P. O. Pasadena, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 12-20-40 (month) (day) (year)
(c) Cemetery or crematory Marley Churchyard
Location Solley, Md.

18 (a) Funeral director T. Singleton
(b) Address Glen Burnie, Md.

19 (a) 12-16 (Date rec'd by registrar) (b) L. A. Brer Registrar

## MEDICAL CERTIFICATION

20. Date of death December 16 19 40 at ____ M

21. I certify that death occurred on the date above stated; that I attended deceased from 12-13- 19 40, to 12- 16 19 40, and that I last saw him alive on 12-14 19 40.

Immediate cause of death: Acute cardiac dilatation — Duration: sudden

Due to: Status asthmaticus — Duration: 1 year

Due to: — Duration:

Other conditions: Arteriosclerosis. Chronic parenchymatous nephritis (Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN: Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. Brer, M. D. (M. D. or other)
Address Pasadena, Md. Date signed 12-16-40

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JAN 6 1941
BUREAU V. S.

12345

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**
County Anne Arundel
City or town Old Glory Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 or 5 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Old Glory Beach Stony Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No. Glen Burnie P.O., Md R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Benjamin Rush

**3.(b) Social Security Number**

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): April 19, 1881

**8. AGE:** Years 59 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Baltimore (Town, county, and state)
10. Usual occupation Care taker
11. Industry or business Shoe
FATHER
12. Name William F Rush
13. Birthplace Balto
MOTHER
14. Maiden name Dont Know Mollie Barrett
15. Birthplace Balto
16. Informant Wm F Rush
Address 612 S Grundy St.
17. (Burial, cremation, or removal. Which?) Date thereof Dec 28 40 (month) (day) (year)
Cemetery or crematory Cedar Hill
Location A A Co Md
18. Funeral director John Ullrich
Address 2008 Orleans St.
19. 12-24 1940 (Date rec'd by registrar) L. A. Brett Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH December 24 1940, at 7 40 P.M.
21. I CERTIFY that death occurred on the date above stated; ~~[illegible]~~
Post-mortem examination 19
~~[illegible]~~ Dec. 24 1940.

| Immediate cause of death | DURATION |
|---|---|
| Coronary thrombosis | sudden |
| Due to | |
| Arterio-sclerosis | unknown |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John M. Claffy Deputy medical examiner M. D. or other
Address Annapolis, Md Date signed 12/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (1) (T)

Bright

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JAN 3 1941
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

12346

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Arnold (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Arnold's (If outside city or town limits, write RURAL and give nearest town)

Street No.: Arnold P.O. A.A. Co Md. (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** George J. Schaeffer

**3.(b) Social Security Number**

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Georgetta Schaeffer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jany 8th 1892

**8. AGE:** Years 48 Months 10 Days 25 If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore Co Md. (Town, county, and state)

10. Usual occupation: Fruit and Vegetable

11. Industry or business: Stand in City Market

FATHER

12. Name: George J Schaeffer

13. Birthplace: Penn.

MOTHER

14. Maiden name: Eliza A Doxzen

15. Birthplace: Balto. Co Md.

16. Informant: Georgetta Schaeffer

Address: Arnold P.O. A.A. Co. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 5th 1940 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. 12 5 1940 (Date rec'd by registrar) J J Murphy Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 3rd 1940, at 12 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 20th 1940 to Dec 3 1940 and that I last saw him alive on Dec 3 1940

Immediate cause of death: Apoplexy Cerebral — DURATION: Sudden

Due to: Arterial hypertension — Several yrs

Due to: Arterio Sclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: J Oliver Purvis M. D. or other

Address: Annapolis Md Date signed: 12/3/40

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JAN 6 1941
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

12347

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Near Pasadena.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 30 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland. County: Anne Arundel.

City or town: Near Pasadena. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: — Mountain Road.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

**3. (a) FULL NAME:** Louis Schramm.

**3. (b) Social Security Number:** —

4. Sex: Male.

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed.

6 (b) Name of husband or wife: Frederica Schramm.

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): February 19, 1852 —

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 88 | 10 | 9 | — hrs. — min. |

9. Birthplace: Germany
(Town, county, and state)

10. Usual occupation: Farmer.

11. Industry or business: Farming

FATHER
12. Name: Peter Louis Schramm.
13. Birthplace: Germany.

MOTHER
14. Maiden name: Louisa Rock.
15. Birthplace: Germany.

16. Informant: Peter L. Schramm
Address: Pasadena. Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 31, 1940 (month) (day) (year)

Cemetery or crematory: Loudon Park Cemetery

Location: Baltimore, Md.

18. Funeral director: Mr & Mrs John W. Teufel & Son

Address: 801 W. Fayette St. Baltimore. Md

19. Dec 30 1940 (Date rec'd by registrar) Mrs. DeAlba Dep. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 28 1940, at 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1940, to Dec 28 1940, and that I last saw him alive on Dec. 28. 1940.

Immediate cause of death: Chronic Valvular Disease of the Heart
Arteriosclerosis

Due to: Chronic Interstitial Nephritis

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:
Of operations: —

Of autopsy: —

DURATION
5 years.
5 years.
5 years

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: James S. Bellingolia M.D.
M. D. or other
Address: Glen Burnie. Md Date signed: Dec 29, 1940

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JAN 6 1941
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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12348

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 28 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Marion Station

(If outside city or town limits, write RURAL and give nearest town)

Street No. ----------

(If rural, give LOCATION)

2.(a) If veteran, name war: ---------

**3.(a) FULL NAME**

Isiah Spady

**3.(b) Social Security Number**

-------

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Black | Married |

6.(b) Name of husband or wife: Mary Spady

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 (?) | Unknown | | --- hrs. --- min. |

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: -----

FATHER

12. Name: Jake Spday

13. Birthplace: Virginia

MOTHER

14. Maiden name: Maria Jackson

15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville State Hospital

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 20, 1940 (month) (day) (year)

Cemetery or crematory: Capeville Cemetery

Location: Capeville, Virginia

18. Funeral director: J. L. P. Linberry

Address: 519 Mosher Street, Balto, Md.

19. Dec 19 1940 (Date rec'd by registrar) E. F. Joyce Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18 1940, at 12:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 20th 1940 to Dec. 18 1940 and that I last saw him alive on December 18 1940

| Immediate cause of death | DURATION |
|---|---|
| Generalized Arteriosclerosis | |
| (diseases of the coronary arteries | |
| Due to: ------- excepted) | |
| Due to: ------- | |
| Other conditions: ------- | |

(Include pregnancy within 3 months of death)

Major findings of operations: ---------

Date of op.

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of: ---

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: Injured at work?

23. SIGNATURE: Herbert L. Simmons M. D. or other

Address: Crownsville, Md. Date signed: 12/19/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

# CERTIFICATE OF DEATH

12349

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 6 N. Southwood Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** Emma Bealer Spalding

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6.(b) Name of husband or wife: John C. Spalding
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): April 14th 1865

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 8 | 5 | ____ hrs. ____ min. |

9. Birthplace: Annapolis Md
(Town, county, and state)
10. Usual occupation: None
11. Industry or business

FATHER
12. Name: William Bealer
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Ellen Hopkins
15. Birthplace: Annapolis Md

16. Informant: Mrs. Carrie Dunn
Address: Annapolis Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec 22nd 1940
(month) (day) (year)
Cemetery or crematory: St Annes
Location: Annapolis Md
16. Funeral director: John Ty Sayler
Address: Annapolis Md.

19. Dec. 21st 1940 J. M. Magruder
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 19 40, at 3 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 19 40, to Dec 20 19 40
and that I last saw h.. alive on Dec 19 19 40

| Immediate cause of death | DURATION |
|---|---|
| Myocarditis | Dec. |
| Coronary Thrombosis | 1 week |
| Due to: Arteriosclerosis | ____ |
| Due to: Hypertension | ____ |
| Other conditions | ____ |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. C. Burd, M. D. or other
Address: Annapolis Md Date signed: 12-22-40

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JAN 6 1941
BUREAU V. S.

12350

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

**1. PLACE OF DEATH:**

County Anne Arundel

City or town Edgewater
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County A.A. Co.

City or town Edgewater Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Thomas Spriggs

**3. (b) Social Security Number** 218-07-0670

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| M | C | Single |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 3 1912

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 28 | 8 | 3 | hrs. min. |

9. Birthplace Edgewater, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business None

FATHER
12. Name Newton B. Spriggs
13. Birthplace Bristol

MOTHER
14. Maiden name Raechal Thomas
15. Birthplace A.A. Co.

16. Informant Newton B. Spriggs
Address Edgewater, Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 1/3/41 (month) (day) (year)

Cemetery or crematory Hope Chapel

Location Edgewater

18. Funeral director T. A. Hardesty & Son
Address Galesville, Md

19. Jan 2 1941 Edward Collenson
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 12/31 1940, at 2:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 30th 1940 to Dec 31st 1940, and that I last saw him alive on Dec 30th 1940.

Immediate cause of death Heart failure

Due to Myo Carditis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION
2 months

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. L. Richardson M. D. or other
Address Arnold Md. Date signed 12/31/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 6 1941
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (164-c)

12351

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Fort George G. Meade, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: -

Stay in hospital or inst. (yrs., or mos., or days): not hospitalized

Stay in this community (yrs., or mos., or days): about three years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Fort George G. Meade Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: -
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: -

**3. (a) FULL NAME:** Paul Edward Syster

**3. (b) Social Security Number:** None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary I. Syster

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 3, 1916

**8. AGE:** Years: 24 Months: 7 Days: 29 If less than one day ____ hrs. ____ min.

9. Birthplace: Bellwood, Pa.
(Town, county, and state)

10. Usual occupation: Soldier

11. Industry or business: U. S. Army

FATHER
12. Name: Edward Ray Syster
13. Birthplace: Pa.

MOTHER
14. Maiden name: Sadie Smith
15. Birthplace: Bellwood, Pa.

16. Informant: Mary I. Syster

Address: Gambrills, Md.

17. ~~Burial~~ Removal Date ~~thereof~~ burial (mile.)
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory:

Location: Bellwood, Pa.

18. Funeral director: T. A. Hardesty & Son

Address: Galesville, Md.

19. Dec. 2, 1940 D. P. Card, Col., M.C.
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 2 1940, at 7 A M

21. I CERTIFY that death occurred on the date above stated; ~~[illegible]~~ Post-mortem to examination ~~[illegible]~~ 19____

Immediate cause of death: Suicide by firearms

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of:

Where did injury occur? in latrine at Ft. Geo. G. Meade
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Ft. Geo. G. Meade

Means of injury: .45 calibre pistol Injured at work?

23. SIGNATURE: John M. Claffy Deputy medical examiner
M. D. or other

Address: Annapolis, Md Date signed: 12/2/40

RECEIVED
JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

12352

# CERTIFICATE OF DEATH

Reg. Dist. No. 23

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Dolley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Dolley
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Dolley Road R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME** Eliza Talbot

**3.(b) Social Security Number**

4. Sex: female
5. Color or race: negro
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife: Jonas Talbot
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feby. 10. 1897
8. AGE: Years: 43 Months: 10 Days: 21 If less than one day: hrs. min.
9. Birthplace: Marley Neck Anne Arunda Md (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: home
FATHER 12. Name: Edward Moore
13. Birthplace: North Carolina
MOTHER 14. Maiden name: Minnie Alexander.
15. Birthplace: North Carolina
16. Informant: Cecil's E. Warren.
Address: 3313 Patton Ave. Baltimore Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-28-40 (month) (day) (year)
Cemetery or crematory: Hall's Church
Location: Marley Neck, Md.
18. Funeral director: Archibald A. Taddie
Address: 2101 Mc Culloh St.
19. Dec. 26 1940 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26, 1940 at 5:10 P. M.
21. I CERTIFY that death occurred on the date above stated: Post-mortem Examination
and that I last saw deceased alive on Dec. 26 1940

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | Sudden |
| Due to: | |
| Arterio-Sclerosis | unknown |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Caffey Deputy Medical Examiner.
M. D. or other
Address: Annapolis, Md. Date signed 12/26/1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

RECEIVED
JAN 6 1941
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12353 2/

Reg. Dist. No.

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 2 months, 12 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Watersville, Mt. Airy

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown

(If rural, give LOCATION)

2.(a) If veteran, name war: ------

**3.(a) FULL NAME:** CARROLL L. TAYLOR

**3.(b) Social Security Number:** ---------

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | black | separated |

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | Unknown | | hrs. min. |

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -----

FATHER 12. Name: John Taylor, dead

13. Birthplace: Maryland

MOTHER 14. Maiden name: Ellean Taylor (Myers)

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-14-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt.

Address

19. Dec. 14 1940 (Date rec'd by registrar) E. F. Joyce Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 6th, 1940 at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 25th, 1940 to Dec. 6th 1940

and that I last saw him alive on Dec. 6th 1940

| Immediate cause of death | DURATION |
|---|---|
| General paralysis of the insane | |
| Due to | |
| Due to | |
| Other conditions: Lues | |

(Include pregnancy within 3 months of death)

Major findings of operations: -------

Date of op.

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury: Injured at work? ---

23. SIGNATURE: Fred L. Armstrong M. D. or other

Address: Crownsville, Maryland Date signed 12/6/40

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JAN 6 1941
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

# CERTIFICATE OF DEATH

12354

94-a

Reg. Diat. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Anne Arundel
City or town: Glen Burnie Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 year
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel.
City or town: Glen Burnie Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Light St. Road.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

**3.(a) FULL NAME:** George Wagner

**3.(b) Social Security Number:** No

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Pauline Wagner (Nee Garreis)
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb. 25 — 1875

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 10 | 23 | hrs. min. |

9. Birthplace: Baltimore. (Town, county, and state)
10. Usual occupation: Cement Block Manufacturer
11. Industry or business: Cement Block (Self)
FATHER 12. Name: Joseph Wagner
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Barbara Smuck.
MOTHER 15. Birthplace: Baltimore
16. Informant: Mrs. George Wagner
Address: Glen Burnie, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21, 1940 (month) (day) (year)
Cemetery or crematory: Holy Cross
Location: Anne Arundel County
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. Dec. 20, 1940 (Date rec'd by registrar) [signature] Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: December 18 1940, at 10 a. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 14, 1940, to Dec. 18, 1940.
and that I last saw h.i.m. alive on December 17, 1940
Immediate cause of death: Coronary thrombosis — DURATION: 4 days
Due to: Arteriosclerosis — 4 days
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: none Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Harry M. Moore M.D. M. D. or other
Address: Glen Burnie Md. Date signed: 12-18-40.

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JAN 6 1941
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

12355

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Jessup

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Georgetown

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) ~~1940~~

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: A A Co.

City or town: Jessup Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Georgetown

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Baby Girl. Washington

**3. (b) Social Security Number:** —

4. Sex: Female

5. Color or race: B

6. (a) Single, married, widowed, or divorced: —

B (b) Name of husband or wife: —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): 12 8 40

**8. AGE:** Years: — Months: Days: If less than one day ____ hrs. ____ min.

9. Birthplace: Jessup Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Asbury Mendell

13. Birthplace: Harmon Md

MOTHER

14. Maiden name: Annie Washington

15. Birthplace: Jessup Md

16. Informant: Annie Washington

Address: Jessup Md

17. (Burial, cremation, or removal. Which?) Date thereof: Dec 9 40 (month) (day) (year)

Cemetery or crematory: Pentecostal Cem

Location: Jessup Md

18. Funeral director: Fred Allen

Address: Jessup Md

19. Dec 9 1940 (Date rec'd by registrar) Clara M Hoesley Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 — 8 — 1940, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 — 8 — 1940, to 12-8-1946, and that I last saw her alive on 12-8-1940

Immediate cause of death: Prematurity 7 mo Fetus

Due to: Stillborn

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B P Warner M. D. or other

Address: Laurel Md Date signed

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JAN 9 1941
U. S.

12356

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-6)

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 mos. 25 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 6 mos. 25 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 538 Orchard St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME:** Joseph T. Wilmer

**3. (b) Social Security Number:** 213 03 8244

4. Sex: Male

5. Color or race: Black

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Mary Wilmer

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): Sept. 6. 1910

**8. AGE:** Years: 30 | Months: 3 | Days: 2 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER
12. Name: Isaac Wilmer
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ida ?
15. Birthplace: Maryland

16. Informant: Hospital Records

Address:

17. Burial
(Burial, cremation, or removal, Which?)

Date thereof: Dec. 11. 1940
(month) (day) (year)

Cemetery or crematory: Foster's Hill

Location: Magnolia, Md.

18. Funeral director: Howard K. McComas

Address: Abingdon, Md.

19. 12/8 40
(Date rec'd by registrar)

E. F. Joyce
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 8, 1940, at 7:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1940, to Dec. 8, 1940 and that I last saw him alive on Dec. 7, 1940

| Immediate cause of death | DURATION |
|---|---|
| General Paralysis of the Insane | unknown |
| Due to | |
| Due to Syphilis | Unknown |
| Other conditions — | |

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Herb T. Winterroe
M. D. or other

Address: Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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DEC 16 1940
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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12357

95-c

# CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 21 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Rural (Cambridge)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**: ISAAC H. WILSON

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Negro | Widowed |

6.(b) Name of husband or wife: Unknown

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Unknown

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | Unknown | | ..... hrs. ..... min. |

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: Arieys Wilson
13. Birthplace: Maryland

MOTHER
14. Maiden name: Heda ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 30. 1940 (month) (day) (year)

Cemetery or crematory: Airey Cemetery

Location: Airey, Md

18. Funeral director: Lewis H. Bayneum
Address: Cambridge, Md

19. 12-28 1940 (Date rec'd by registrar) J. J. Murphy Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26, 1940, at 7.15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 5, 1940, to Dec. 26, 1940 and that I last saw him alive on December 25, 1940

| Immediate cause of death | DURATION |
|---|---|
| Generalized arteriosclerosis with decompensation; meaning Cardiac decompensation. C.W.G.R. | Unknown |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Herbert P. Mintzrode M. D. or other

Address: Crownsville, Maryland Date signed: 12/26/40

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BUREAU V. S.

12358

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

**1. PLACE OF DEATH:**

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 6 yrs. 8 mos. 16 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

**3. (a) FULL NAME**: MARY WILSON

**3. (b) Social Security Number**: -------

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | black | single |

6.(b) Name of husband or wife: ------

8.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1884

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 56 | Unknown | | ..... hrs. ..... min. |

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: -----

FATHER
12. Name: John Wilson
13. Birthplace: New Jersey

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof: 12/11-40 (month) (day) (year)

Cemetery ~~or crematory~~: Hospital

Location: Crownsville

18. Funeral director: Supt

Address

19. 12/11 1940 (Date rec'd by registrar) E. F. Joyce Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: December 7th 1940 at 7:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 21st, 1923, to Dec. 7th 1940 and that I last saw her alive on Dec. 7th 1940

| Immediate cause of death | DURATION |
|---|---|
| Broncho pneumonia of the left lung | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ------

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ---- Date of

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -----

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 12/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

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JAN 6 1941
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